

Index of Exhibits

Exhibit A	Gulf Pines Hospital Records of Derrick Charles
Exhibit B	Houston Northwest Medical Center Psychiatric Records of Nancy Phillips
Exhibit C	Affidavit of Leroy Phillip
Exhibit D	Transcript of Patillo Investigation Company Interviews
Exhibit E	Statement of Charges of Patillo Investigation Company
Exhibit F	Social Security Records of Nancy Phillips
Exhibit G	Houston Police Department Offense Report of Incident between Leroy Phillips and Lincoln Charles
Exhibit H	Death Certificate of Herman Charles
Exhibit I	Autopsy Report of Herman Charles
Exhibit J	Dr. Lawrence Ginsberg Records Of Derrick Charles
Exhibit K	San Jacinto County District Clerk Files of Joyce Charles
Exhibit L	Letter of Dr. Lawrence Ginsberg to State Habeas Counsel Bob Wicoff
Exhibit M	Klein Independent School District Records of Derrick Charles
Exhibit N	Texas Youth Commission Records of Derrick Charles

Exhibit O	Medicaid Records of Nancy Phillips
Exhibit P	Red Oak Psychiatric Associates Records of Nancy Phillips
Exhibit Q	Confidential Psychological Evaluation Clinical Interview & Mental Status of Nancy Phillips
Exhibit R	Report of Dr. Terry A. Rustin
Exhibit S	Texas Youth Commission Employee Data Sheet of Simona McCowan
Exhibit T	Texas Youth Commission Summary Appraisal Forms of Simona McCowan
Exhibit U	HighPoint North School Records of Derrick Charles
Exhibit V	TDCJ Classification RecordsOf Derrick Charles.
Exhibit W	Affidavit of Bette Burke
Exhibit X	UTMB Managed Care/TDCJ Records Of Derrick Charles.
Exhibit Y	Affidavits of Connie Williams
Exhibit Z	Crowley Voucher
Exhibit AA	<i>In Camera</i> Hearing
Exhibit BB	Transcript of December 15, 2005 <i>Castellano</i> Pretrial Hearing finding Sid Crowley ineffective

Exhibit CC	Petitioner's Original Disciplinary Petition <i>Commissioner for Lawyer Discipline v. James S. Crowley</i> , Cause No. 05-CV-140898, 240 th Judicial District Court of Fort Bend County, Texas
Exhibit DD	Agreed Judgment of Public Reprimand Cause No. 05-CV-140898, 240 th Judicial District Court, Fort Bend County, Texas
Exhibit EE	Order Granting Defendant's Motion for Investigative Fee in Indigent Case
Exhibit FF	February 26, 2003 Pretrial Hearing
Exhibit GG	Letter from Dr. Jerome Brown May 14, 2003
Exhibit HH	Affidavit of Dr. Jerome Brown
Exhibit II	Derrick Charles Unsworn Declaration In State Habeas Corpus Proceeding
Exhibit JJ	Affidavit of Alternate Juror Thomas Gregory Mayo
Exhibit KK	"The Team Concept in a Capital Case"
Exhibit LL	2001 Stetler article
Exhibit MM	Private Investigator Licensing Application of Joe Patillo
Exhibit NN	Declaration of Christine Bickham
Exhibit OO	Declaration of Lincoln Charles
Exhibit PP	Declaration of Lawrence Charles

Exhibit QQ	Declaration of Christopher Charles
Exhibit RR	Cypress Creek Hospital Records of Christine Bickham
Exhibit SS	Dr. Eileen Starbranch Records of Christine Bickham
Exhibit TT	Red Oaks Psychiatry Associates Records of Lawrence Charles
Exhibit UU	Affidavit of Joe Patillo from <i>Ex Parte Geno Capoletti Wilson</i>
Exhibit VV	Affidavit of Connie Williams from <i>Ex Parte John Reyes Matamoros</i>
Exhibit WW	Affidavit of Connie Williams from <i>Ex Parte Derrick Sean O'Brien</i>
Exhibit XX	Affidavit of Willie Tyrone Trottie
Exhibit YY	Affidavit of Connie Williams from <i>Ex Parte Robert Mitchell Jennings</i>
Exhibit ZZ	Connie Williams Judgment and Findings of Facts & Conclusions of Law
Exhibit AAA	Connie Williams Orders to File and Show Cause

Exhibit

A

Gulf Pines Hospital Records
Of Derrick Charles

1 JUSTON TEXAS

77090

004834

BILLING NO.

431716

3 A/R NO.

431716

PATIENT'S LEGAL NAME (L.F.M.)

CHARLES DERRICK

5 SEX

M

6 RACE

B

7 BIRTH DATE

09-06-1982

8 AGE

010

9 HEIGHT

10 WEIGHT

11 SS

12 MS

13 RELIGION/CHURCH

S

/

OR

14 PATIENT'S LEGAL ADDRESS

#227

CITY/STATE

HOUSTON

ZIP=77060

713

TX 445-5617

17 ES 18 PATIENT'S EMPLOYER

19 EMPLOYER ADDRESS

CITY/STATE

20 TELE

21 SOCIAL SECURITY NO.

22 EMPLOYEE ID

23 LOE

24 OCCUPATION

25

26 LOR

27 COUNTY CODE

28 COUNTY

201

HARRIS

30 RESPONSIBLE PARTY

PHILLIPS NANCY

31 RESPONSIBLE PARTY'S ADDRESS

#227

CITY/STATE

HOUSTON

ZIP=77060

713

TX 445-5617

33 ES 34 RESPONSIBLE PARTY'S EMPLOYER

35 EMPLOYER ADDRESS

CITY/STATE

36 TELE

37 SOCIAL SECURITY NO.

38 EMPLOYEE ID

39 LOE

40 OCCUPATION

41

42 LOR

43 COUNTY CODE

44 COUNTY

201

HARRIS

NONE

DATE OF ADMISSION:

3/9/93

DATE OF DISCHARGE:

3/11/93

HOUR OF ADMISSION:

HOUR OF DISCHARGE:

TOTAL DAYS:

ADMITTING PHYSICIAN:

FINAL DIAGNOSES

AXIS I:

Oppositional Defiant Disorder
 Depressive disorder, No 5

AXIS II:

No dx

AXIS III:

R10 Partial Compulsive Syndrome Disorder

AXIS IV:

(3)

AXIS V:

GAF - 45 on discharge

PROCEDURES/OTHER:

CONSULTANTS:

CODES

313.81
 296.20

ADMITTING
 DIAGNOSES
 CODES:

DISCHARGE STATUS:

☐ HOME 01☐ OTHER HOSPITAL 02☐ SNF 03☐ ICF 04☐ HOME HEALTH 06☐ AMA 07☐ EXPIRED 20☐ OTHER 05

I HAVE EXAMINED AND APPROVED THIS COMPLETE MEDICAL RECORD

PHYSICIAN SIGNATURE

3/11/93

DATE

FACE SHEET

HCA GULF PINES HOSPITAL

DISCHARGE SUMMARY

PATIENT NAME: DERRICK CHARLES DATE OF ADM: 03/09/93
PATIENT NO: 00-48-34 DATE OF DIS: 03/11/93
ATTENDING PHYSICIAN: LAWRENCE D. GINSBERG, M.D.

ADMITTING DIAGNOSES:

Axis I: Oppositional Defiant Disorder
 Depressive Disorder, Not Otherwise Specified
Axis II: No Diagnosis
Axis III: Rule Out Partial Complex Seizure Disorder
Axis IV: (3)
Axis V: GAF - 30 - On Admission

FINAL DIAGNOSES:

Axis I: Oppositional Defiant Disorder
 Depressive Disorder, Not Otherwise Specified
Axis II: No Diagnosis
Axis III: Rule Out Partial Complex Seizure Disorder
Axis IV: (3)
Axis V: GAF - 45 - On Discharge

REASON FOR ADMISSION: This is the first HCA Gulf Pines Hospital admission for this 10 year old Black male. The patient was initially evaluated in the office on the day prior to admission in the presence of his mother and stepfather. The patient had been violent towards his peers at home and at school. He had been depressed. In school the patient lost his temper, argued with adults, refused chores. He was easily annoyed, he was angry and resentful and blamed others for his actions. He had witnessed violent behavior between mother and stepfather. The patient had been suspended from school. The patient was admitted because of serious dysfunctionality at home and at school.

MENTAL STATUS EXAMINATION ON ADMISSION: The patient was casually dressed. He was not verbal. His affect was blunted. His mood was depressed. His associations and thought processes were appropriate. There was no evidence of delusions, hallucinations, or suicidal ideations. His short term memory was fair to good. His orientation was X 3. He was alert. His intellectual functioning was good.

HCA GULF PINES HOSPITAL

DISCHARGE SUMMARY

PATIENT NAME: DERRICK CHARLES

PAGE 2

PHYSICAL EXAMINATION ON ADMISSION: As per Dr. James P. Zucconi. Skin showed some dryness as well as on the ^{posterior} elbows and anterior knees. Heart rate was 66. Respiratory rate was 14. He had some slurring of speech but was understandable. The rest of examination was unremarkable.

LABORATORY DATA: March 10th, urine drug screen was negative. March 10th, urinalysis was within normal limits except for 1+ mucous. CBC was within normal limits. Chemistries were within normal limits except for total bilirubin of 1.3, total cholesterol of 218, LDL cholesterol 137. Hypothyroid panel was within normal limits. RPR was non-reactive. Folic acid level and Vitamin B12 level was within normal limits. Electrocardiogram on admission revealed sinus rhythm, QT 0.36.

HOSPITAL COURSE: The patient was treated on the Children's Psychiatric Unit with daily physician visits, individual therapy, family therapy, group therapy, activities therapy, and biofeedback. On the second day of admission patient's mother because she missed her child signed a 24 hour letter requesting discharge. The patient was discharged the following day by Art Smith, M.D. who was on call for me.

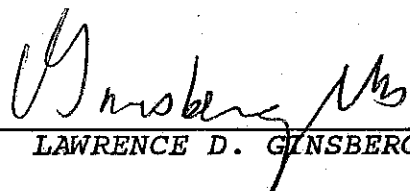
PROGNOSIS ON DISCHARGE: Is fair only with continued treatment.

DIET ON DISCHARGE: Regular.

PHYSICAL ACTIVITY: No restrictions.

MEDICATIONS ON DISCHARGE; None.

AFTERCARE: Dr. Smith instructed the patient's family to call me with regard to outpatient follow up. The patient's family will be instructed to repeat his bilirubin level as an outpatient.



LAWRENCE D. GINSBERG, M.D.

LDG:ld

DD: 04/06/93

DT: 04/07/93

DISCHARGE

SUMMARY/PLAN

CHARLES DERRICK 10
M 09061982 030993
GINSBERG 160

NURSING DISCHARGE SUMMARY

GENERAL INFORMATION

Date of Discharge 3/11/93 Time _____
Discharge Status: ☒ MD Order ☐ AMA ☐ AMA Release Signed
Mode of Discharge: ambulatory
Accompanied by: Nancy Phillips Relationship mother

CONDITION OF PATIENT ON DISCHARGE

MEDICAL STATUS:

stable

EMOTIONAL STATUS:

bright

MEDICATIONS

Prescriptions to Patient/Other: ☐ Yes ☐ No ☐ Nonapplicable
List Medications:

NAME	DOSAGE	FREQUENCY
<u>NONE</u>		

Psychotropic Medication Management Information provided to patient/other via Medication Teaching Sheet(s). ☐ Yes ☐ No

Patient/Other instructed to contact physician/pharmacist for information concerning prescribed **NON-psychotropic** medications. ☐ Yes ☐ No

SPECIFIC INSTRUCTIONS/TEACHING

NONE

RESTRICTIONS:

NONE

DIET reg

PHYSICAL ACTIVITY as tolerated

SIGNATURES

Above information has been explained to me and I understand the contents.

Nancy Phillips 3-11-93
Patient/Significant Other Relationship

M Jackson ENC 3/11/93
Nurse Date

SOCIAL SERVICE DISCHARGE PLAN

LIVING ARRANGEMENTS FOLLOWING DISCHARGE

With Whom/Name of Facility mother - Nancy Phillips
Address _____

FOLLOW UP CARE

Community Agency/Individual recommended for aftercare:

Name Dr. Hinsberg Phone # 893-4111

Address _____

Initial Appointment Date call Dr. Monday

Name _____ Phone # _____

Address _____

Initial Appointment Date _____

Support Groups:

☐ AA ☐ NA ☐ CA ☒ GPH Aftercare ☐ Multi-Family

Other _____

Comments:

Tues 7-8 parent support
Wed 6³⁰-7³⁰ parenting skills

SCHOOL/VOCATIONAL/WORK/PLAN

OTHER SIGNIFICANT INFORMATION

Patient/Other Instructed to contact _____
should assistance be required following discharge.

SATISFACTION SURVEY COMPLETED ☐ YES ☐ NO

I give permission for Gulf Pines Hospital to contact me at ☐ Home/
☐ Work, for a period not to exceed 6 months to determine my satisfaction
with services provided. I can be contacted at _____
between the hour _____ and _____

Signed: _____

SIGNATURES

Above Information has been explained to me and I understand the contents.

Nancy Phillips 3-11-93
Patient/Significant Other Relationship Date

Signature of Social Worker

Signature of Psychiatrist

DATE 3/8/93 TIME 1600 LOCATION ROPA

FINDINGS/RECOMMENDATIONS:

Pt is violent + aggressive behavior
+ depression - severely impaired - Sup. from school
Admission advised

[Signature]
Signature of Physician

PHYSICIAN ADMITTING NOTE/PRELIMINARY PSYCHIATRIC ASSESSMENT/TREATMENT PLAN

JUSTIFICATION FOR ADMISSION

Patient must meet one or more of the following criteria. Check applicable item(s).

- ☒ a. Recent suicide attempt (within 72 hours) or suicidal ideation requiring suicide precautions.
- ☐ b. Physically assaultive behavior threatening the life or safety of other persons.
- ☐ c. Self-mutilating behavior.
- ☐ d. Acute onset or exacerbation of psychotic symptoms (hallucinations, delusions, disordered thinking) of sufficient severity to jeopardize the patient's ability to live safely outside of a hospital.
- ☒ e. Acute deterioration of patient's behavior, coping skills or ability to care for self that creates a risk of harm to self or other persons.
- ☒ f. Acute onset of severe mental anguish that overwhelms the patient to the extent that the patient cannot function outside of a hospital.
- ☐ g. Meets DSM-III-R criteria for Major Depression (documented in Psychiatric Assessment).
- ☐ h. Meets DSM-III-R criteria for Mania (documented in Psychiatric Assessment).
- ☐ i. Meets DSM-III-R criteria for alcohol withdrawal delirium (documented in Psychiatric Assessment) or is in impending alcohol withdrawal delirium based on a history of severe alcohol dependence and abrupt cessation of alcohol intake.
- ☐ j. Severely disabled as a result of psychoactive substance-induced withdrawal, delirium, delusional disorder or amnesic disorder (DSM-III-R criteria documented in Psychiatric Assessment).
- ☐ k. Patient requires inpatient treatment and rehabilitation for psychoactive substance dependence based on:
(All four of the following must be met)
 - 1) extensive or prolonged use of psychoactive substance(s); and
 - 2) significant impairment of health or of family, social, occupational or academic functioning as a result of substance dependence; and
 - 3) complicating medical problems (including residual impairment secondary to psychoactive substance withdrawal, delirium, delusional disorder or amnesic disorder) or failure of a structured outpatient rehabilitation program to achieve abstinence from psychoactive substances; and
 - 4) a reasonable medical expectation that inpatient treatment and rehabilitation will improve the patient's ability to maintain abstinence from psychoactive substances upon which the patient is dependent.
- ☐ l. Patient requires inpatient treatment and rehabilitation for psychoactive substance dependence based on a reasonable medical determination that such inpatient treatment and rehabilitation are necessary to significantly reduce the risk of:
 - 1) rapid deterioration of patient's behavior, coping skills, or ability to care for self that creates risk of harm to self or other persons; or
 - 2) relapse or continuing psychoactive substance use resulting in significant impairment of health or of family, social, occupational, or academic functioning.
- ☐ m. Other _____

IMPORTANT: EACH CRITERION CHECKED ABOVE MUST BE REFLECTED
IN THE PATIENT'S PSYCHIATRIC ASSESSMENT.

(CONTINUED ON BACKSIDE OF FORM)

HCA Gulf Pines
Hospital

431716

CHARLES DERRICK 10
M 09061982 030993
GINSBERG 160

PRELIMINARY PSYCHIATRIC ASSESSMENT

1. Chief complaint (in patient's own words if possible) violent behavior / severe aggressive behavior
2. History of present illness including alcohol/drug use and precipitants justifying hospitalization: violent towards peers at home + in school Agitated at school, loses temper, argues + adults, refuses doses, jerky + easily annoyed, angry + resentful, blames others. Has witnessed mother + step-father's violent behavior towards each other. Now suspended from school
3. Known physical status and allergies: birth @ 8 wks of age Birth wt 4lbs
Stillborn occ. in stressed, Gelman chn 11 wks born 3 months ago
4. Brief mental status:
 - a. General appearance/behavior casually dressed, relatively unoriented
 - b. Affect/Mood affected blunted mood depressed
 - c. Associations and thought processes appropriate
 - d. Thought content and structure (including delusions, hallucinations, suicidal ideation) No delusions/hallucinations/suicidal ideations
 - e. Cognitive functions:
 - Memory short term fair to good
 - Orientation X 3
 - Intellectual functioning good
5. Inventory of patient's assets Family supportive of tx
6. Provisional Diagnosis: Axis I. Oppositional Defiant Disorder, Depressive Disorder, NOS
Axis II. No dx
Axis III. RR Partial Complex Seizure Disorder
7. Criteria for Discharge enthused, violent behaviors
reptg into family dynamics
8. Projected length of stay 2-3 wks
9. Preliminary discharge plan home vs RTC

10. Physician preliminary plan of care:

Focus of Treatment	Goals
<u>violent behaviors</u>	<u>eliminate</u>
<u>depression</u>	<u>enthused</u>

01 X31R12
889030 S8913
061 08302410

Admitting Physician

Attending Physician

3/9/97
Date

Date

1315
Time

Time

**Gulf Pines
Hospital****PHYSICIAN ADMITTING ORDERS - CHILDREN'S PROGRAM****I. THE HISTORY AND PHYSICAL** is to be completed within 24 hours by:

____ Attending Physician

☒ Other (please name) Zuccini, Matthew**II. VITAL SIGNS**

____ Routine

☒ Special (indicate frequency) q Shift**III. LAB AND RADIOLOGY**☒ Core Panel☒ CBC w/DIFF.☒ Hypothyroid Panel (T4, T3 Uptake, FTI, TSH)☒ Comprehensive Toxicology☒ UA☒ RPR☒ Urine Pregnancy☒ EKGOther: ly level, Vit B 12 level, Serum Prolate, Stage-dependent EKG**CLINICAL JUSTIFICATION (s)**☒ R/O Metabolic Disorder☒ R/O Infectious Disease☒ R/O Pregnancy☒ R/O ToxicityOther: R/O Coagulation disorder**IV. DIET:**☒ Regular

____ Special (SPECIFY): _____

V. PRECAUTIONS

____ No Precautions

☒ Suicide (15 min. checks)

____ Seizure/Medical (30 min. checks)

☒ Assault/Homicidal (15 min. checks)

____ Detox (30 min. checks)

____ Elopement (15 min. checks)

CLINICAL JUSTIFICATION (s): Has been assaultive at home + school**VI. THERAPEUTIC RESTRICTIONS**☒ No Restrictions

____ Unit Restriction (7-Day Expiration)

____ Indoor Facility Restriction (3-Day Expiration)

____ Physical Search for Contraband

CLINICAL JUSTIFICATION (s): _____**VII. THERAPEUTIC COMMUNICATION LIMITATIONS (ALL EXPIRE IN 7 DAYS)**☒ No Limitations

____ Telephone

____ Mail

____ Visitors

CLINICAL JUSTIFICATION (s): SPECIFY EXACT LIMITATIONS, (eg. when limited from telephone, what mail/visitors are limited), DURATION OF LIMITATIONS, AND JUSTIFICATION FOR EACH LIMITATION) _____

(Continued on back)

431716

CHARLES DERRICK 10
M 09061982 030993
GINSBERG 160

VIII. ASSESSMENT ORDERS

☒ Psychosocial Assessment
☒ Psychological Evaluation, ☒ Full Battery ☐ Brief Battery
by whom: Karen Redus Psy D
☒ Educational Assessment, by whom: John Goldstein, Ph.D
Other: _____

IX. THERAPY ORDERS

Assessment Program:

☒ SUCCESS ☒ RT ☒ ROPES

☒ Individual Therapy/Program Counseling; by whom: Shirley Moore, LPC
☐ Family Therapy/Family Program Counseling; by whom: Shirley Moore, LPC

☒ Other: Tai Chi
Other: _____

[Signature]
Admitting Physician

3/9/93
Date

Attending Physician

Date

noted in Jackson etc
Signature of Nurse

3/9/93
Date

3. After copy 3 is used "X" out remaining unused lines.

Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s) may be administered if column is not checked

3-10-93

2^o ch

4/2

Book

1

1

1

100

3/10/93
0915

Dr Smith to care 3/10/43, 5 PM &

3/15/93 7AM

3/10 0930 H. w. / m. a. t. h. a. o.

NKA

Height: 54"
Weight: 77lbs

PATIENT INFORMATION

931716

CHARLES DERRICK 10
09061982 030973
GINSBERG 140

004834 05

Q4: (1) Oppositional Defiant Disorder
(2) Major Depressive Disorder NOS

NOS

1

437JTP

01 2312220 2312220
000000 00000000
000000 00000000

001217 22

3. After copy 3 is used "X" out remaining unused lines.

Another brand of a generically equivalent product, identical in dosage form and content of active ingredient(s) may be administered if column is not checked

ALLERGIES

PATIENT INFORMATION

431716

CHARLES DERRICK 10
M 09061982 030993
GINSBERG 140

7-22-64

RECEIVED
FBI
SEP 23 2009
COMMUNICATIONS SECTION
FBI - MEMPHIS

004824 02

☒ **DISCHARGE ORDERS**
Patient to be discharged on 3/11/93

☐ **TRANSITION ORDERS**
From: _____
Level of Care _____ Program _____ Date _____
TO: _____
Level of Care _____ Program _____ Date _____

Primary Discharge Diagnoses: Axis I: Oppositional defiant d/o
Axis II: Depressive d/o - NOS
Axis III: no dx

Physical Activity Limitations none Diet regular

Current Medications
1. /
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

May patient take home own medications? ☒ Yes ☐ No Prescriptions Written? ☐ Yes ☒ No

Aftercare 1. Psychiatric Follow up with: to call Mr. Ginsberg on Mon.
2. Labs as Outpatient; Specify: _____
Where _____ When _____
3. IT with: _____
4. FT with: _____
5. Aftercare Group(s) at GPH _____
6. Outpatient/Community Group(s); Specify: _____
7. Other Medical Follow up with: regular M.P.
8. Other: _____

Other _____

Physician's Signature [Signature] Date 3/11/93 Time 11:15 **431716**
Nurse's Signature [Signature] Date 3/11/92 Time 1330 **CHARLES DERRICK 10**
09061982 030993
GINSBERG 160
004834 US

CLISBERG 190
N 0041985 030043
(CHARLES DERRICK 10
HATJIP

004834 20

000821 02

01-20-09 190
01-20-09 030023
01-20-09 DEWICK 10

137JTP

HCA GULF PINES HOSPITAL

HISTORY AND PHYSICAL

PATIENT NAME: DERRICK CHARLES DATE OF ADM: 3/9/93
PATIENT NUMBER: 00-48-34
ATTENDING PHYSICIAN: LAWRENCE GINSBERG, M.D.
AUTHOR OF REPORT: JAMES P. ZUCCONI, M.D.
DATE OF REPORT: MARCH 10, 1993

According to Derrick, who is a ten year old Black male, he is being hospitalized here at Gulf Pines Hospital for being suspended at school, talking back to teachers, and not doing work. Documentation on the chart shows oppositional behavior.

PAST MEDICAL HISTORY: This child has been well. He says there is no past psychiatric or somatic hospitalizations. He did varicella in the past. No surgeries and no past hospitalizations. No history of broken arms or lacerations.

No important dental history. Patient claims he has an allergy to chocolate and he is on no present medications.

As far as a diet, the patient does not utilize alcohol, tobacco, caffeine, or recreational drugs.

Derrick lives at home with his mother, father, and an eleven year old brother with whom he fights but according to the patient, not too bad.

REVIEW OF SYSTEMS: The skin shows some distal dryness as well as on the posterior elbows and anterior knees and Keri lotion will be applied to these areas. He has no signs of shortness of breath, difficulty with breathing, periumbilical pain, heart palpitations, vision, or hearing deficit. No complaints of chronic constipation, dysuria, ambulation, or balance problems.

On examination, the head shows no signs of trauma. Tympanic membranes and ears normal. Conjunctiva of the eyes normal as well. The pupils are equal and reactive to light and accommodation. The patient has no anterior or posterior cervical nodes palpable. The chest is clear upon auscultation. There are no rales, rhonchi, or wheezing. The abdomen is soft and there is no liver or spleen palpable. There is no heart murmur. The heart rate at 66, respiration at 14. The patient is a non-circumcised male. Testes x 2, down and palpable. There are no signs of either axillary or genital hair appreciated. There is some enlargement of the testes and Tanner for the genitalia is stage II.

Patient is 5/5 muscle power. He can do jumping jacks, deep knee bends, walk on his heels and toes without abnormality. Romberg is negative. His finger to nose and heel to shin coordination is appropriate. (continued on page 2)

ADMISSION PSYCHIATRIC ASSESSMENT

DATE OF ADM: 03/09/93

ATTENDING PHYSICIAN: LAWRENCE D. GINSBERG, M.D.

DATE OF DICTATION: 03/09/93

HISTORY OF PRESENT ILLNESS: This is the first HCA Gulf Pines Hospital admission for this 10 year old Black male. The patient was initially evaluated in the office the day prior to admission in the presence of his mother and stepfather. The patient had been violent towards his peers at home and at school. He had been depressed in school. The patient loses his temper, argues with adults, he refuses chores, he is ~~touch and~~ easily annoyed, he is angry and resentful and blames others for his actions. He has witnessed a violent behavior between mother and stepfather. The patient has been suspended from school. The patient is admitted because of his severe dysfunctionality at home and at school.

DEVELOPMENTAL HISTORY: The patient lives with mother and stepfather and brother who is age 11. His 11 year old brother is doing well. No religious preference is noted. He is in the 3rd grade at Calvert Elementary in the Aldine Independent School District. Problems in school are as noted above.

PAST MEDICAL HISTORY: Is remarkable for seizures at eight weeks of age. The patient was premature and weighed four pounds at birth. The patient stutters occasionally when stressed. He had a left elbow iron burn three months ago.

FAMILY HISTORY: The patient has a cousin who has Attention-Deficit Disorder. Paternal uncle has sickle cell anemia. Paternal aunt has diabetes.

MENTAL STATUS EXAMINATION ON ADMISSION: The patient is casually dressed. He is relatively non-verbal. His affect is blunted. His mood is depressed. His associations and thought processes are appropriate. There is no evidence of delusions, hallucinations, or suicidal ideations. His short term memory is fair to good. His orientation is X 3. The patient is alert. His intellectual functioning is good.

ASSETS: The patient's family is supportive of treatment.

HCA GULF PINES HOSPITAL
ADMISSION PSYCHIATRIC ASSESSMENT

PATIENT NAME: DEREK CHARLES

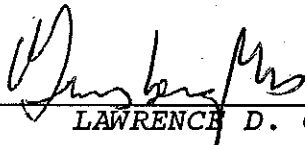
PAGE 2

DYNAMIC FORMULATION: The patient is demonstrating oppositional and defiant behaviors. In addition, it appears the patient may be depressed. He has few neurovegetative symptoms of depression but he has some depressive equivalents. In addition the patient had a seizure at eight weeks of age and has violent behaviors. The possibility of a Partial Complex Seizure Disorder cannot be ruled out.

PROVISIONAL DIAGNOSIS:

Axis I: Oppositional Defiant Disorder
Depressive Disorder, Not Otherwise Specified
Axis II: No Diagnosis
Axis III: Rule Out Partial Complex Seizure Disorder
Axis IV: (3)
Axis V: GAF - 30 - On Admission

TREATMENT PLAN: The patient will be treated with full modalities on the Children's Unit. He will have daily physician visits, individual therapy, family therapy, group therapy, activities therapy, and biofeedback. He will have a physical examination, laboratory evaluation, and psychological testing. Medications will be deferred until evaluation is completed.



LAWRENCE D. GINSBERG, M.D.

LDG:ld
DD: 03/09/93
DT: 03/10/93

PSYCHOLOGICAL REPORT

Name: Derrick Charles

MR#: 4834

Age: 10

Adm: 3/9/93

Date of Birth: 9/6/82

Date of examination: 3/10/93

Examiner: Karan Redus, Ph.D.

Date typed: 3/15/93

REASON FOR REFERRAL

Derrick was referred for psychological evaluation by Dr. Larry Ginsberg, M.D., after Derrick's admission to Gulf Pines Hospital. The purpose of this evaluation was to aid in diagnosis and treatment planning.

HISTORY

It was reported that this was Derrick's first hospitalization at Gulf Pines, and that he had been admitted due to increasing behavioral problems. It was reported that he had become violent and oppositional toward peers and adults at both home and school. He apparently had been suspended from school recently. It was also reported that he was arguing with adults, refusing classes was prone to become easily annoyed, angry and resentful. Derrick reported that he had not had any behavioral problems until this year, but could not describe what if anything was different about this year in school.

It was reported that Derrick had a febrile seizure at 8 months of age. It was also reported that he walked and talked at approximately 18 months of age. No other significant illnesses or injuries were reported.

Derrick lives with his mother and stepfather, and it was reported that he had witnessed some violent behavior between them. Derrick denied the presence of hallucinations, delusions or suicidal ideation.

TECHNIQUES UTILIZED

Clinical Interview
{Benton Visual Retention Test

Children's Apperception Test
Projective Drawing
Rorschach

TEST BEHAVIOR

Derrick was a 10 year old male of approximately average height and weight. He was appropriately groomed and casually dressed. He appeared cooperative as he willingly went with the examiner to the consultation room and completed all assigned tasks upon first request. However, Derrick made very little eye contact and he verbalized very little and only in response to examiner questions. During the testing on several occasions questions had to be repeated as it seemed as if he had not heard the question at all. It was not clear whether this was due to inattention, preoccupation or being unable to hear adequately. During parts of the testing Derrick worked in a deliberate and purposeful manner. In other parts of the testing he appeared to respond in a somewhat hasty and impulsive manner. For example he attempted to reach across the table for additional picture cards before the examiner could hand him the card. On other occasions he attempted to grab additional cards and give answers while the examiner was trying to inquire about a previous answer. In all instances he accepted redirection easily.

RESULTS

On the Benton Visual Retention Test he obtained an error score of 6 which was somewhat lower than would be expected given his age and level of intellectual functioning. This score indicated the absence of apparent impairments in visual memory functioning.

Personality testing suggested that he tends to intermingle feelings with thinking during problem-solving and decision-making behaviors, and that he may be more inclined to display feelings and less concerned about carefully modulating or controlling those displays. There were also indications of a laxness and apparent difficulty in modulating affect, and he may thus have difficulty dealing with emotional stimuli. In fact he may display a tendency to avoid emotional stimuli or to be uncomfortable around emotional situations. An important side effect of this tendency is that he may be avoiding or being overly cautious in many of the every day exchanges that contribute to development.

His self esteem appeared to be very low with likely feelings of being inadequate or unsuccessful. His self image is likely to include significant negative features and he may compare himself unfavorably to others. He may experience a significant sense of vulnerability. Although he may anticipate and seek harmonious interactions with others, he may also be somewhat cautious about creating and/or maintaining close emotional ties with others. In some of his responses there were themes of conflict in relationships with others, and he may see adults as being either somewhat emotionally aloof or as somewhat critical. He may struggle with angry feelings toward females. It also appeared that he may view relationships toward the world with a sense of doubt and discouragement and may tend to anticipate gloomy outcomes to his efforts regardless of the quality of that effort.

Derrick displayed a marked tendency to narrow or simplify stimulus fields. This style may promote negligence in translating information and can create the potential for a higher frequency of behaviors that do not coincide with social demands or expectations. He is likely to scan his environment in a hasty or haphazard manner and to thus miss or neglect critical bits of information, which can also lead to the risk of behaviors that do not coincide with social demands. He also displayed significant difficulty in shifting attention. It appeared that he is likely to make less conventional more individualized responses to stimuli, which may be the result of an orientation to maintain distance from and thus cope with an environment perceived as threatening, demanding or ungiving. In addition he appeared to have significant problems with perceptual accuracy. It appeared likely that irritating or painful affect was contributing to the perceptual and/or mediational difficulty he experienced.

SUMMARY

Derrick was a 10 year old male who appeared to have very low self esteem and who appeared to be experiencing irritating or painful affect that was interfering with his perceptual and/or mediational activities. He displayed a marked tendency to narrow or simplify stimulus fields and to hastily or haphazardly scan his environment. Because he may miss, neglect or distort critical cues or bits of information, this style can create the potential for a higher frequency of behaviors that do not coincide with social demands or expectations. It also appeared that Derrick was likely to have difficulty in modulating affect and is more inclined to display feelings and be less

concerned about modulating or controlling those displays. He may have a sense of hopelessness or discouragement about his relationships to the world and may expect gloomy outcomes regardless of his efforts. Some of his responses suggested that problems with impaired perceptual accuracy could be due either to attentional and concentration problems, neurological problems or decompensation and internal preoccupation related to depressive affect. He did give an unusually large number of responses to portions of the testing, which can be associated with a Bipolar process. This along with the significant impairments in his cognitive processing suggest that he will need to be monitored for the possible development of more significant affective and cognitive disturbances. Also further testing could rule out the presence of neurological problems.

DIAGNOSTIC IMPRESSIONS

Axis 1 Oppositional Defiant Disorder
 Depressive Disorder, NOS
 features of Attention Deficit Disorder
 Axis11 see Educational assessment
 Axis111 rule out seizure disorder
 Axis1V moderate
 Axis V 35 on admission

RECOMMENDATIONS

1. Individual, group and family therapy is indicated, with a focus on a structured behavioral program.
2. Derrick is in much more significant distress than he indicate verbally. Because his verbal skills appear to be less well developed, Derrick will need significant help in learning ways to successfully deal with his feelings. Interventions should be made on a more concrete level. As observed in the testing, writing and drawing appear to be more comfortable modalities for Derrick and could be utilized in helping him learn more appropriate coping behaviors.
3. He will need self esteem building activities.
4. He would benefit from activities that provide structured practice in increasing his purposeful attention and concentration.
5. Because there was some question as to whether he was accurately hearing the examiner at times, a hearing exam if it has not been done, or a speech and language assessment could be considered.

6. Despite his hesitance to verbalize, Derrick does appear to want positive interactions and does appear motivated to succeed and do well.

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